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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

30233

State File No.

Registration District No. 100 Primary Registration District No. 5390 Registrar's No. 63

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Springcreek
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: x
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution x (Specify whether
In this community most of her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33

(c) City or town Rural 0
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location) 0

(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME Rose Golden

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex female

5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife David Golden

6. (c) Age of husband or wife if alive x years

7. Birth date of deceased Dec (Month) 14 (Day) 1862 (Year)

8. AGE: Years 79 Months 9 Days x If less than one day hr. min.

9. Birthplace Madison Co (City, town, or county) Mo U (State or foreign country)

10. Usual occupation housewife

11. Industry or business x

FATHER
12. Name David Golden
13. Birthplace --- (City, town, or county) Tenn (State or foreign country) 1

MOTHER
14. Maiden name Margeret Poor
15. Birthplace --- (City, town, or county) Ky (State or foreign country) 1

16. (a) Informant Mrs Becker
(b) Address 12021 Oggleston Ave Chi,

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/16/42 Ill (Month) (Day) (Year)
(c) Place: burial or cremation Cedar Grove Cem

18. (a) Signature of funeral director [signature]
(b) Address Salem Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

1177

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
year 1942 hour 9 minute 45 A M.

21. I hereby certify that I attended the deceased from Aug 28, 1942, to Sep 13, 1942, that I last saw her alive on Sep 11, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease

Due to

Due to Chronic Nephritis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓ (Specify type of place)
While at work? ✓ (e) Means of injury

23. Signature N. J. Dillon (M. D. or other)
Address Salem Mo Date signed Sep. 16. 42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 1042929
Date Filed 10-7-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Ore.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
8-21-41
29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30233

Registration District No. 100 Primary Registration District No. 5390 Registrar's No. 63

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Rose Golden

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 14 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 7 If less than one day or min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 9-16-42 (Date received local registrar) (b) Jas. D. McLeod (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY